

accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories in § 422.2420(b) or (c) will generally be the most accurate method.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contracts incurring the expense.

(iii)(A) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

(B) Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013]

§ 422.2430 Activities that improve health care quality.

(a) *Activity requirements.* Activities conducted by an MA organization to improve quality must fall into one of the categories in paragraph (a)(1) of this section and meet all of the requirements in paragraph (a)(2) of this section.

(1) *Categories of quality improving activities.* The activity must be designed to achieve one or more of the following:

(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.

(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge plan-

ning, and post-discharge reinforcement by an appropriate health care professional.

(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.

(iv) To promote health and wellness.

(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Such activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improving activities or make new quality improvement initiatives possible.

(2) The activity must be designed for all of the following:

(i) To improve health quality.

(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) To be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(b) *Exclusions.* Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:

(1) Those that are designed primarily to control or contain costs.

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.

(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.

(4) Those activities that can be billed or allocated by a provider for care delivery and that are reimbursed as clinical services.

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including ICD-10 implementation costs in excess of 0.3 percent of total revenue under this part, and maintenance of ICD-10 code sets adopted in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.

(7) All retrospective and concurrent utilization review.

(8) Fraud prevention activities.

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.

(10) Provider credentialing.

(11) Marketing expenses.

(12) Costs associated with calculating and administering individual enrollee or employee incentives.

(13) That portion of prospective utilization review that does not meet the definition of activities that improve health quality.

(14) Any function or activity not expressly permitted by CMS under this part.

§ 422.2440 Credibility adjustment.

(a) An MA organization may add a credibility adjustment to a contract's MLR if the contract's experience is

partially credible, as determined by CMS.

(b) An MA organization may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as determined by CMS.

(c) For those contract years for which a contract has non-credible experience for their MLR, sanctions under § 422.2410(b) through (d) will not apply.

(d) CMS defines and publishes definitions of partial credibility, full credibility, and non-credibility and the credibility factors through the notice and comment process of publishing the Advance Notice and Final Rate Announcement.

§ 422.2450 [Reserved]

§ 422.2460 Reporting requirements.

For each contract year, each MA organization must submit a report to CMS, in a timeframe and manner specified by CMS, which includes but is not limited to the data needed by the MA organization to calculate and verify the MLR and remittance amount, if any, for each contract, such as incurred claims, total revenue, expenditures on quality improving activities, non-claims costs, taxes, licensing and regulatory fees, and any remittance owed to CMS under § 422.2410.

§ 422.2470 Remittance to CMS if the applicable MLR requirement is not met.

(a) *General requirement.* For each contract year, an MA organization must provide a remittance to CMS if the contract's MLR does not meet the minimum MLR requirement required by § 422.2410(b) of this subpart.

(b) *Amount of remittance.* For each contract that does not meet the MLR requirement for a contract year, the MA organization must remit to CMS the amount by which the MLR requirement exceeds the contract's actual MLR multiplied by the total revenue of the contract, as provided in § 422.2420(c), for the contract year.

(c) *Timing of remittance.* CMS deducts the remittance from plan payments in a timely manner after the MLR is reported, on a schedule determined by CMS.